Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Individual Care Plan

a. Responsibility for Service Plan Development. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(check each that applies)*:

☐	Registered nurse, licensed to practice in the State
☐	Licensed practical or vocational nurse, acting within the scope of practice under State law
☐	Licensed physician (M.D. or D.O)
X	Case Manager (qualifications specified in Appendix C-3)
☐	Case Manager (qualifications not specified in Appendix C-3). *Specify qualifications*:
☐	Social Worker. *Specify qualifications:*
☐	Other (*specify the individuals and their qualifications):*

b. Service Plan Development Safeguards. *Select one:*

○	Entities and/or individuals that have responsibility for service plan development *may not provide* other direct waiver services to the participant.
X	Entities and/or individuals that have responsibility for service plan development *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:
	Individuals or their legal representatives are offered a choice of service providers for the array of waiver services. The Case Management Agency may be one potential provider amongst a list of individuals and other agencies. The individual (or the legal representative) selects the provider of their choice. During Client Interviews, performed by the Department, the client is asked if they were offered the opportunity to choose their service provider and asked if they were aware they could change their service provider.

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as

appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

Clients or Legal representatives are an active component in service plan decisions. This is evidenced by legal representatives signing the applications, decision regarding Waiver vs institutional care, and the care plan.

Individuals are given a copy of the Clients Rights Brochure that outlines client rights, responsibilities and case management responsibilities.

For Attendant Care Service, a team is involved in the development of the service plan. This team, at a minimum, includes the client, legal representative, licensed nurse, the Case Manager, the Department.

For Residential Care Service, a team of individuals are involved in the development of service plan. This team at a minimum includes, the service provider, the case manager, the client, the legal representative (if applicable).

d. Service Plan Development Process In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

The Case Manager initiates the care plan by scheduling a meeting with the applicable parties. The care plan development is performed initially and is re-evaluated every six months. Client receive a case management contact at least each quarter. The annual and the six month contacts are required to be face to face and the other two quarterly contacts may be conducted by phone or face to face. Case Management activities may occur more frequently if applicable.

For Attendant Care Services, a nursing comprehensive assessment is completed by a licensed nurse. Included is a nursing plan of care which identifies contingency planning, tasks, supervision, and monitoring. The Case Management entity is responsible to obtain the initial, annual, or as requested by the nurse manager documentation from a physician supporting that the applicant/client is medically stable and competent to self-monitor the service.

A comprehensive needs assessment is performed by the Case Management entity. The social model assessment (from the Case Management entity) demonstrates service needs and goals as declared or demonstrated by the applicant/client or family members/friends. The social model assessment contains information regarding client and demographic information, informal supports, legal representatives, emergency and medical contacts, physical health information (nutrition, impairments, current health status, medication usage), cognitive/emotional status (cognition, behavior, emotional well being, mental health), functional assessment (ADL's, IADL's, supervision/structured environment, special needs), home environment, and services currently receiving and willing to receive (federal/state/local/private/informal). Financial eligibility is verified during the assessment process.

Once the assessment has been completed, the Case Manager will review the findings of the assessment to the applicant/client (or the legal representative). The Case Manager will provide what may be available through the Waiver, by describing the services and the tasks, or other potential resources for the individual. The services, program options, and potential service providers are discussed. A care plan is developed which includes the authorization of services based on client needs, provider availability, and client choice of Waiver services and providers. The client signs the care plan indicating they are in agreement with the care plan.

Individuals are informed of the availability of Case Management and may contact the Case Manager in between the required quarterly contacts, and must contact Case Management if a change has occurred in the care plan or program eligibility. If the Case Manager becomes aware of a change in between the quarterly contacts (service provider/family member/State/other) generated by concern, complaint, or documented/published – the Case Manager will initiate case management activity with the client or the legal representative.

Client needs, which are not provided in the Waiver, are explored by the Case Manager and/or the client. Goals are established, acknowledgement of client's rights and responsibilities are discussed and agreed upon, and choice of Waiver vs institutional care is verified.

If the individual is denied based on ineligibility of the HCBS services, the individual will be provided with a denial notice and their right to appeal. Other options, if applicable, will be provided to the individual to assist them in accessing assistance.

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

Through the comprehensive needs assessment, potential risks are identified. The Case Manager and the client will review the assessment results and develop a care plan to diminish risk. Informal supports and other programs (such as a state or county funded program) are companions to the Waiver services.

If the service is provided by an individual provider the client has to establish a contingency plan that is documented on the ICP. The contingency plan may include contacting another provider, family member, community resource or if the service is not critical, rescheduling the service contact.

Paid service providers assure the Department they will contact the Case Managers when changes occur in the client's health status or service needs.

For Attendant Care Services, the nursing care plan must identify incidents reportable to the nurse on an immediate basis. Incidents that result in client injury or require medical care are reportable incidents to the nurse. The nurse is responsible to report these incidents to the Case Manager. If it has been determined by the Case Manager the event or incident is reportable regarding abuse, neglect, or exploitation, the Department will be contacted..

The State conducts Case Management Reviews, Provider Reviews, and Client Interviews to identify inappropriate service delivery or actions and to address the client needs and satisfaction with the services.

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

Case Management agencies are informed of newly enrolled, on-going open, and recently closed Qualified Service Providers. The information provided to the Case Management entity is: provider name and contact information, provider type, provider number, provider approved service(s) and applicable rates, and provider (approved) global endorsements.

The summarized information is shared with the applicant/client/legal representative for review and provider selection. The individual checks and signs the care plan indicating they were afforded the opportunity to choose their service provider(s).

When a change in service provider occurs between case management contacts – the client (or legal representative) may contact the case manager requesting the change in provider and the contact is verified by case management documentation.

Applicants/Clients recruit potential service providers as evidenced on provider enrollment documentation. The potential providers must still comply with provider enrollment standards and requirements.

At a minimum, the Care Plans are valid for a six month period of time. Subsequent Care Plans require client/legal representative acknowledgement of care plan acceptance.

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

All Individual Care Plans are required to be forwarded to the State Medical Services Division/HCBS. An HCBS Program Administrator receives and reviews the Care Plans. Issues relating to inconsistencies or incompleteness are returned to the Case Management entity for resolution.

The comprehensive assessments/narratives are available through a web-enabled data system accessible to the Medical Services Division/HCBS staff.

These tools are used in Case Management reviews performed by the Department. The comprehensive assessment, Individual Care Plans, authorizations, and other applicable information are used to determine services have been appropriately authorized by the Case Management entity.

The goal is to review case management entities each year (at a minimum) either through an on-site or desk review. The goal is to review 10% of the medicaid wavier case files yearly. The Department employs two staff persons that are responsible for reviews.

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. *Specify the minimum schedule for the review and update of the service plan:*

O	Every three months or more frequently when necessary
X	Every six months or more frequently when necessary
O	Every twelve months or more frequently when necessary
O	Other schedule (*specify*):

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies)*:

☐	Medicaid agency
☐	Operating agency
X	Case manager
☐	Other (*specify):*

Appendix D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

As a requirement for Case Management, the Case Management entity is responsible to monitor the service plan. The client, legal representative, and family plays a significant role in monitoring the care plan. The client or legal representative must report changes to the case manager relating to the client's home, self, living arrangement, or service provision for care plan evaluation and revision.

If the client' care needs cannot be met by the care plan and heath welfare and safety requirements cannot be met, Case Management must initiate applicable changes or terminate Waiver services.

Case Management (phone or on-site) contacts occur after 30 days from initial care plan implementation and at least quarterly. Case Management activities are not limited to quarterly contacts.

Face to face contacts are required initially, semi-annually, and semi-annually thereafter. Face to face contacts are also required if the client's service needs change. In addition at a minimum, a phone contact must occur quarterly.

When contacted, clients are afforded the opportunity to discuss potential issues relating to current or potential service provision. Case Managers also request if the client has had or will have any changes relating to care plan needs or service provision.

In the event the client no longer qualifies, financially, for Waiver services, the client or legal representative agrees to contact the Case Management entity. The Case Manager would then initiate or assist with other program referrals and provide closure notices to the State and a termination notice to the client.

With the assistance of the client/legal representative back up plans are identified in the event deviations from the care plan occur. The contingency plans are identified in the care planning process and documented on the individual care plan.

b. Monitoring Safeguards. *Select one:*

○	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may not provide* other direct waiver services to the participant.
X	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:
	The Department oversees monitoring through Case Management Reviews, through Case Management training/technical assistance, and through complaint resolution.